GENERAL INFORMATION

This chapter contains general information related to AHCCCS billing rules and requirements. Policies regarding submission and processing of fee-for-service claims are communicated to providers via such channels as this *AHCCCS Billing Manual for IHS/Tribal Providers* and the *Claims Clues*.

Claims must meet AHCCCS requirements for claims submission. In the absence of specific policies, AHCCCS endeavors to follow Medicare policy guidelines as closely as possible.

In addition to Medicare requirements, AHCCCS follows the coding standards described in the *UB-92 Manual; International Classification of Diseases, 9th Revision (ICD-9) Manual; Physicians' Current Procedural Terminology (CPT) Manual;* and *Health Care Procedure Coding System (HCPCS) Manual* as well as the *First Data Bank Blue Book* for pharmacy information.

CLAIM SUBMISSION REQUIREMENTS

Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or are not submitted on the correct form will be returned to you without being processed. If a claim is returned, you must refile a legible copy of the claim on the correct type of claim form and submit it within the required time frame.

AHCCCS retains a permanent electronic image of all paper claims submitted, requiring providers to file clear and legible claim forms.

Claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") may not be used. Permanent self-adhesive correction tape must be used to cover information that should not appear on the claim.

Any documentation submitted with a claim or subsequent to the submission of a claim also is imaged and linked to the claim image. Documentation is not required when resubmitting claims if the required documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim.

All claims should be mailed to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

You are responsible for delivery of claims to AHCCCS, including the provision of adequate postage.

CLAIM SUBMISSION REQUIREMENTS (CONT.)

AHCCCS also accepts HIPAA-compliant 837 electronic fee-for-service claims from all certified submitters. Providers and clearinghouses must successfully complete testing to be certified to submit 837 transactions.

For more information, contact the AHCCCS Electronic Claims Submission Unit at (602) 417-4242 or (602) 417-4706.

CLAIM SUBMISSION TIME FRAMES

In accordance with ARS §36-2904 (H), an initial claim for services provided to an AHCCCS recipient must be received by AHCCCS not later than 6 months from the date of service, unless the claim involves retro-eligibility. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

Claims initially received beyond the 6- month time frame, except claims involving retro-eligibility, will be denied.

If a claim is originally received within the 6-month time frame, you have up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

As defined by ARS §36-2904 (H)(1) a "clean claim" is:

> A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

RETRO-ELIGIBILITY

Retro-eligibility affects a claim when no eligibility was entered in the AHCCCS system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

Fee-for-service claims are considered timely if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of eligibility posting. Claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.

RETRO-ELIGIBILITY (CONT.)

Adjustments to paid claims must be received no later than 12 months from the AHCCCS date of eligibility posting. This time limit does not apply to adjustments which would decrease the original AHCCCS payment due to collections from third party payers.

BILLING AHCCCS RECIPIENTS

Arizona Revised Statute §36-2903.01(N) prohibits you from billing AHCCCS-eligible recipients, including QMB Only recipients, for AHCCCS-covered services:

> Upon oral or written notice from the patient that the patient believes the claims to be covered by the system [AHCCCS], a provider or nonprovider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or nonprovider has verified through the administration that the person has been determined ineligible, has not yet been determined eligible or was not, at the time services were rendered, eligible or enrolled:
>
> 1. Charge, submit a claim to, or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.
> 2. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for system covered care or services unless specifically authorized by this article or rules adopted pursuant to this article.

RESUBMISSIONS, ADJUSTMENTS, AND VOIDS

The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to you on the AHCCCS Remittance Advice. You should correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim time frame (See Chapter 17, Correcting Claim Errors, and Chapter 18, Understanding the Remittance Advice).

When resubmitting a denied claim, you must submit a new claim form containing all previously submitted lines. The original AHCCCS Claim Reference Number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame.

You do *not* need to resubmit documentation unless specifically requested to do so.

RESUBMISSIONS, ADJUSTMENTS, AND VOIDS (CONT.)

☑ To resubmit a denied CMS 1500 claim:

- ✓ Enter "A" in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim in the field labeled "Original Ref. No."
- ✓ Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.
  - ☒ Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

  Example:

  You submit a three-line claim to AHCCCS. Lines 1 and 3 are paid, but Line 2 is denied.

  When resubmitting the claim, you should resubmit all three lines. If only Line 2 is resubmitted, the AHCCCS system will recoup payment for Lines 1 and 3.

☑ To resubmit a denied UB-92 claim:

- ✓ Write the word "Resubmission" and the CRN of the denied claim in the "Remarks" field (Field 84).
  - ☒ If Field 84 is used for other purposes, write the word "Resubmission" and the CRN at the top of the claim form.

☑ To resubmit a denied ADA 2002 claim:

- ✓ Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number).

After a claim has been paid by AHCCCS, errors may be discovered in the amounts or services that were billed. These errors may require submission of an adjustment to the paid claim. For example, you may discover that additional services should be billed for a service span or that incorrect charges were entered on a claim paid by AHCCCS.

When adjusting a paid claim, you must submit a new claim containing all previously submitted lines. If any previously paid lines are blanked out, the AHCCCS system will assume that those lines should not be considered for reimbursement, and payment will be recouped.

The original CRN must be included on the claim to enable the AHCCCS system to identify the claim being adjusted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame or for being a duplicate of a previously paid claim.

Every field can be changed on the adjusted claim except the service and billing provider ID number and tax ID number. If these must be changed, you must void the claim and submit a new claim.

RESUBMISSIONS, ADJUSTMENTS, AND VOIDS (CONT.)

☑ To adjust a paid CMS 1500 claim:

- ✓ Enter "A" in Field 22 and the CRN of the claim to be adjusted in the field labeled "Original Ref. No."
- ✓ Resubmit the claim in its entirety, including all original lines if the claim contained more than one line.
  - ☒ Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

  Example:

  You submit a three-line claim to AHCCCS. All three lines are paid.

  You discover an error in the number of units billed on Line 3 and submit an adjustment.

  When submitting the adjustment, you should resubmit all three lines. If only Line 3 is resubmitted, the AHCCCS system will recoup payment for Lines 1 and 2.
- ✓ An adjustment for additional charges to a paid claim must include all charges -- the original billed charges plus additional charges.

  Example:

  You bill for two units of a service with a unit charge of $50.00 and are reimbursed $100.00. After receiving payment, you discover that three units of the service should have been billed.

  When adjusting the claim, you should bill for three units and total billed charges of $150.00 (3 units X $50.00/unit). The AHCCCS system will pay the claim as follows:

Allowed Amount (3 units)	$150.00
Previously Paid to Provider	<$100.00>
Reimbursement	$ 50.00

  If you billed for the one additional unit at $50.00, the AHCCCS system would recoup $50.00 as shown below:

Allowed Amount (1 unit)	$50.00
Previously Paid to Provider	<$100.00>
Reimbursement (Amount recouped)	<$ 50.00>

RESUBMISSIONS, ADJUSTMENTS, AND VOIDS (CONT.)

☑ To adjust a paid UB-92 claim:

- ✓ Write the word "Adjustment" and the CRN of the claim to be adjusted in the "Remarks" field (Field 84).
  - ☒ If Field 84 is used for other purposes, write the word "Adjustment" and CRN at the top of the claim form.

☑ To adjust a paid ADA 2002 claim:

- ✓ Enter the CRN of the denied claim in Field 2 (Predetermination/Preauthorization Number).

When voiding a claim, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.

Unlike resubmissions and adjustments, you should submit only the line(s) to be voided. Lines that should be not be voided should be blanked out to avoid recoupment of payment for those lines.

☑ To void a paid CMS 1500 claim:

- ✓ Enter "V" in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

☑ To void a paid UB-92 claim:

- ✓ Use bill type XX7 (for example 117, 727, etc.) and enter the CRN of the claim to be voided in the "Remarks" field (Field 84).
  - ☒ If Field 84 is used for other purposes, write the CRN at the top of the claim form.

☑ To void a paid ADA 2002 claim:

- ✓ Write the word "VOID" and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

OVERPAYMENTS

A provider must notify AHCCCS of an overpayment on a claim by submitting an adjustment to the paid claim. Providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.

The claim will appear in the Adjusted Claims section of the Remittance Advice showing the original allowed amount and the new (adjusted) allowed amount. (See Chapter 18, Understanding the Remittance Advice)

GENERAL AHCCCS BILLING RULES

Most of the rules for billing AHCCCS follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by AHCCCS.

☑ Billing must follow completion of service delivery

- ✓ A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

☑ Billing multiple units

- ✓ If the same procedure is provided multiple times on the same date of service, the procedure code must be entered once on the claim form.
- ✓ The units field is used to specify the number of times the procedure was performed on the date of service.
- ✓ The total billed charge is the unit charge multiplied by the number of units.

☑ Medicare and third party payments

- ✓ By law, AHCCCS has liability for payment of benefits after all other third party payers, including Medicare.
- ✓ You must determine the extent of third party coverage and bill all third party payers prior to billing AHCCCS.

NOTE: See Chapter 7, Medicare/Other Insurance Liability.

☑ Age, gender and frequency-based service limitations

- ✓ AHCCCS imposes some limitations on services based on recipient age and/or gender.
- ✓ Some procedures have a limit on the number of units that can be provided to a recipient during a given time span.
- ✓ The AHCCCS Office of Special Programs may revise these limits as appropriate.

☑ Emergency services claims

- ✓ All claims are considered non-emergent and subject to applicable prior authorization and Indian Health Service referral requirements unless the provider clearly identifies the service billed on the claim form as an emergency.
- ✓ On the UB-92 claim form, the Admit Type (Field 19) must be "1" (emergency) or "4" (newborn) on all emergency inpatient and outpatient claims.
  - ☒ All other Admit Types, including a "2" for urgent, designate the claim as non-emergent.
- ✓ On the CMS 1500 claim form, Field 24I must be marked to indicate that the service billed on a particular claim line was an emergency.

GENERAL AHCCCS BILLING RULES

☑ Emergency services claims (Cont.)

- ✓ AHCCCS staff will review ADA 2002 dental claims for adults to determine if the service provided was emergent.
  - ☒ Adults are eligible for emergency dental services only.

☑ Recoupment

- ✓ Under certain circumstances, AHCCCS may find it necessary to recoup or take back money previously paid to a provider.
- ✓ Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.
- ✓ Upon completion of the recoupment, AHCCCS will send a letter explaining the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the recoupment.
- ✓ If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), you will be afforded additional time to provide justification for re-payment.
- ✓ If a copy of the recoupment letter and the claim are submitted within the stipulated time period, AHCCCS will override time edits.
  - ☒ If the claim is submitted without a copy of the letter, AHCCCS will not override time edits, and the claim will be denied.
- ✓ In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter.
- ✓ The time span allowed for submission of a clean claim will be the *greatest* of:
  - ☒ Twelve months from the date of service, or
  - ☒ Twelve months from the date of eligibility posting for a retro-eligibility claim, or
  - ☒ Sixty days from the date of the recoupment letter.
- ✓ If recoupment is initiated by the AHCCCS Office of Program Integrity as a result of identified misrepresentation, you will not be afforded additional time to resubmit a clean claim.

☑ Double-sided copies of claims

- ✓ Do not submit double-sided multiple-page claims.
- ✓ Each claim page must be on a separate piece of paper with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3).

GENERAL AHCCCS BILLING RULES (CONT.)

- ☑ Multiple-page UB-92 claims
  - ✓ To ensure that all pages of a multiple-page UB-92 claim are processed as a single claim:
    - ☒ Claim pages should be numbered (e.g., 1 of 3, 2 of 3, 3 of 3).
    - ☒ All pages should be clipped or rubber-banded together (Do not staple).
    - ☒ Totals should not be carried forward onto each page.
    - ☒ The "001" total should be entered on the last page only.
- ☑ Zero charges
  - ✓ AHCCCS will key revenue and procedure codes billed with zero charges.
  - ✓ However, revenue codes with zero charges will not be considered for reimbursement.
- ☑ Mothers and newborns
  - ✓ Newborns whose mothers are AHCCCS recipients are eligible for AHCCCS services from the time of delivery.
  - ✓ Newborns receive separate AHCCCS identification numbers, and services for a newborn must be billed separately using the newborn's AHCCCS ID.
    - ☒ Services for the newborn that are included on the mother's claim will be denied.
  - ✓ Contact the AHCCCS Verification Unit for newborn eligibility and enrollment information (See Chapter 2, Eligibility).
- ☑ Change in recipient eligibility
  - ✓ If the recipient is ineligible for any portion of a service span, those periods should not be billed to AHCCCS.
  - ✓ If a recipient's eligibility changes, each eligible period should be billed separately to avoid processing delays.
- ☑ Change in reimbursement rate
  - ✓ It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.
    - ☒ Reimbursement of inpatient claims is based on the rate in effect on the admission date.
  - ✓ When a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rate, the claim must be split.

DOCUMENTATION REQUIREMENTS

Medical review is a function of the AHCCCS Claims Department and is performed to determine if services are provided according to AHCCCS policy related to medical necessity and emergency services. Medical review also is performed to audit appropriateness, utilization, and quality of the service provided

In order for this medical review to take place, providers may be asked to submit additional documentation for fee-for-service CMS 1500 claims identified in the AHCCCS claims processing system as near duplicate claims. The documentation is necessary to allow the AHCCCS Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

Near duplicate claims are claims for the same procedure, same day, same recipient, and different providers.

Near duplicate claims for certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, Medical Review staff will release the claim for payment, assuming that the claim has not failed any other edits.

Near duplicate claims for certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care , and hospital visits) may pend for review. If the documentation substantiates the services, Medical Review staff will release the claim for payment, assuming that the claim has not failed any other edits.

If no medical documentation is submitted, Medical Review staff will deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with Medical Review denial code “MD008 - Resubmit with progress notes.” Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

It is expected that certain E&M codes such as 99291 (Critical care, evaluation and management) and 99231-99233 (Subsequent hospital care) will frequently fail the near duplicate edit because it is feasible that a recipient could be seen by more than one provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

DOCUMENTATION REQUIREMENTS (CONT.)

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill AHCCCS for CPT Code 99291 for April 22 for Mr. Jones.

Either claim may fail the near duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the Medical Review nurse will deny the claim with denial code "MD008 - Resubmit with progress notes."

While it is impossible to offer specific guidelines for each situation, the table on Page 4-12 is designed to give providers some general guidance regarding submission of documentation. Also, not all fee-for-service claims submitted to AHCCCS are subject to Medical Review.

DOCUMENTATION REQUIREMENTS (CONT.)

CMS 1500 Claims		
Billing For	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Emergency room visits	Emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, consult reports	Documentation should be specific to code billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.
UB-92 Claims		
Billing for	**Documents Required**	**Comments**
Observation	All documents required by statute and observation records	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, pathology report	Information must substantiate fetal demise
NICU/ICU tier claims	All documents required by statute	MD orders and MD progress notes to substantiate level of care billed
Outlier	All documents required by statute	

DOCUMENTATION REQUIREMENTS (CONT.)

Providers should *not* submit the following unless specifically requested to do so:

- ☑ Emergency admission authorization forms
- ☑ Patient follow-up care instructions
- ☑ Nurses notes
- ☑ Blank medical documentation forms
- ☑ Consents for treatment forms
- ☑ Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- ☑ Ultrasound/X-ray films
- ☑ Medifax information
- ☑ Nursing care plans
- ☑ Medication administration records (MAR)
- ☑ DRG/Coding forms
- ☑ Medical documentation on prior authorized procedures/hospital stays
- ☑ Entire medical records